MET LIFE

Choice of Dentist	Program allows you to choose any dentist you wish. Payments to Preferred Dental Providers (PDP) are based on negotiated fees. Payments to non preferred dentists are based on Reasonable and Customary (not billed) charges.	
Maximum Benefit/Deductible	$1,000 per year per person $50 deductible per year per person; $150 family maximum	$1,500 per year per person $50 deductible per year per person; $150 family maximum
Type I	STANDARD Plan Pays (No deductible)	ENRICHED Plan Pays (No deductible)
110 Initial Oral Exam	100%	100%
0120 Periodic Oral Exam	100%	100%
X Rays	100%	100%
1110/20 Prophylaxis	100% (Twice per calendar year)	100% (Twice per calendar year)
1201/03 Fluoride Treatment (children up to the age 19)	100%, 1x per year	100%, 1x per year
1351 Sealant - per tooth	Not Covered	Not Covered
Type II	*	*
Fillings: (silver)		
2110/40 one surface	75% Non PDP/100% PDP	75% Non PDP/100% PDP
2120/50 two surfaces	75% Non PDP/100% PDP	75% Non PDP/100% PDP
2130/60 three surfaces	75% Non PDP/100% PDP	75% Non PDP/100% PDP
2131/61 four or more surfaces	75% Non PDP/100% PDP	75% Non PDP/100% PDP
Root canals:		
3310 Anterior	75%	75%
3320 Bicuspid	75%	75%
3330 Molar	75%	75%
3410 Apicoectomy	75%	75%
Extractions:		
7110 single tooth	75%	
7120 Each additional tooth	75%	75%
7210 surgical extraction of erupted tooth	75%	75% 75%
Periodontics: (gum treatment)	75%	
4341 Periodontal scaling & root planning-per quadrant	75%	75%
4210 Gingivectomy/gingivoplasty - per quadrant	75%	75% 75%
4910 Periodontal maintenance procedures		
Type III	*	*
Crown & Bridge		
2930 Prefabricated stainless steel	50%	50%
2790/91/92/6790/91/92 Full cast crown	50%	50%
2750/51/52/6750/51/52 Porcelain fused to metal crown	50%	50%
Pontics:	50%	50%
Full Cast 6210/11/12	50%	50%
Porcelain fused to metal 6240/41/42		
Prosthodontics (Dentures)	50%	50%
5110 Complete upper	50%	50%
5120 Complete lower	50%	50%
5213/14 Partial upper or lower - cast metal base	50%	50%
ORTHODONTIA		
Consultation	Not Covered	Adult & Child covered at 50% after a one time deductible of $50 per person. $1,000 lifetime maximum
Evaluation	Not Covered	
Records	Not Covered	
Children -Normal Class II	Not Covered	
Adult - Normal Class II	Not Covered	
8750 Retention	Not Covered	

VISION		
Examination	Not Covered	Not Covered
Single Vision Lenses	Not Covered	Not Covered
Bifocal Lenses	Not Covered	Not Covered
Trifocal Lenses	Not Covered	Not Covered
Contact Lenses - Non-Elective	Not Covered	Not Covered
Contact Lenses –Elective	Not Covered	Not Covered
Frames	Not Covered	Not Covered
	* All Type II and III charges subject to annual deductible	* The above reimbursements are exclusive of gold